

Obstetric and Medico-Legal Challenges Posed by Sudden Immigrant Shift in a Southern Mediterranean Island

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Abstract

The article examines some of the obstetric management problems and medico-legal implications encountered in Malta, a small island located between North Africa and Italy. The obstetric national service is one of European standards but problems do arise, at times in conveying optimal service to the patient for a number of reasons, including language and multi-faceted socio-cultural barriers. These barriers, may set up obstacles, the effects of which may be gleaned from the study of similar or quasi-similar ethnic groups in countries with long experience of immigrants, be they regular or irregular. The problems encountered by the sub-Saharan pregnant female are referred to in particular. A number of the obstetric management challenges are also examined from possible current or future medico-legal involvement. The problem of Court ordered caesarean section is looked at a little closer, vis-à-vis constitutional rights in Malta and other countries.

Keywords: Immigrants; Demographic shifts; Malta; Obstetric challenge; Sub-Sahara; Medico-legal

Introduction

Malta is an island covering 316 km² (122 square miles) situated 80km south of Italy and 333 km north of Libya. It is a full member of the European Union and although its national language is Maltese, its official languages are Maltese and English with a substantial number of people speaking Italian quite fluently, but very few speak Arabic and essentially none speak any of the languages from regions of the Horns of Africa.

Up till 2005, in the island of Malta, the non-Maltese population was only 3% of the total (12,112% :4,713 British, 585 German, 493 Libyans) [1]. By 2011, there was an increase of 4.8% of non-Maltese residents, a jump of 65.8% from 2005. In 2004, Malta became a full member of EU community and this partly explains the increase in non-Maltese population. However, as from 2001, Malta saw the arrival of a large number of sub-Saharan migrants – see statistics [2].

Quoting the Maltese Prime Minister [3].

“The tiny island of Malta has received 17,743 mainly African migrants this decade - the equivalent, in Britain, of 2.5 million people. Between 2008 and 2012 Malta received, on average, the highest number of asylum seekers compared to its national population: 21.7 applicants per 1,000 inhabitants [4-11]. In 2011, most of these asylum applications were submitted by nationals of Somalia, Nigeria, Eritrea and Syria [12]. In 2012, more than half of the requests were by Somalian nationals alone [13].” (Figure 1).

The Law and Reality

Luxembourg, Cyprus and Malta are among seven member states whose laws make no specific provision for maternity care for undocumented migrants. Therefore, on paper, Malta is one of the member states with restrictive laws regarding undocumented migrants' access to sexual and reproductive health services. However, undocumented migrants and asylum seekers, whose claims have been denied, are still entitled to “core benefits” that include sexual and reproductive health services on an administrative basis [4]. There are limits to the use of such services, in gynaecology. For example treatment of infertility excludes advanced investigation. However, with regard to

the pregnant immigrant, all services are available to ensure maternal and fetal well-being.

Challenge to the System

In considering the obstetric challenges posed by immigrants arriving in large numbers and over a short period of time, reference is here being made to the great majority of immigrants, being Somalis, followed by Eritrean, Nigerians, Ethiopians and the very minimal being Zimbabwe, Cameroon and Congo. Here, some of the challenges posed by this demographic shift to the Maltese Maternity Service are looked at.

The Maternity Service in Malta, is of European standard, with a neonatal mortality rate of 4.09 per 1000 live births and a caesarean section rate of 30.2% [5]. However well established and efficient, such a service is, the immigrant challenge does pose a learning curve, in dealing with sudden substantial numbers of sub-Saharan pregnant patients. There are difficulties generated by a number of factors, such as communication barriers, socio-economic background, religious beliefs and traditions, pertinent to the ethnicity and geographic regions of origin and transit.

There is also the element of managing pregnant patients with illnesses, rarely currently seen in Malta, but rife at the place of origin, be they nutritional, infective or multifactorial. Pregnancy healthcare was among the disciplines benefitting from the work of the Migrant Health Liaison Office, established in 2008 with the aim of assisting migrants to access health care in Malta. Pregnancy care has been strongly in its scope as evidenced by the training of cultural mediators and health care professionals, to facilitate migrants' integration into the health system,

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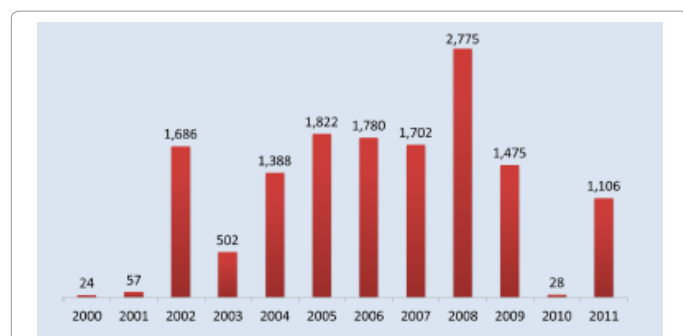


Figure 1: Number of asylum seekers reaching Malta between 2000 – 2011. [Courtesy of Dr Christine Cassar].

coning on health and social care professionals, as well as delivering lectures to midwives and nurses working in antenatal, postnatal and delivery wards [6].

Discussion

In this article, in view of the sparse relevant local publications, reference is often made to similar problems in other countries. It is the firm belief of this author, that the multi-faceted aspect of medical care of sub-Saharan (in particular) obstetric patients' needs specific care management, incorporating emphasis on communication, privacy, social cultural and religious aspects on the central obstetric pillar. In this regard, it is interesting to note that a very recently issued call for the post of Consultant Obstetrician and Gynaecologist at the National Maternity Unit (Mater Dei Hospital), carries, among the list of duties required of the successful candidate, those of "being expected to develop and clinically lead an Obstetric service focusing on the care of minority groups in particular disadvantaged Maltese and non-Maltese citizens with emphasis on irregular immigrants or individuals seeking refugee status. This service will include a call/recall system to ascertain that these patients comply with their antenatal care so as to reduce risk throughout pregnancy and the postpartum period. This antenatal care will also include an outreach service involving a team composed of medical and non-medical personnel including social workers [7]."

It is encouraging that the signs of the times are being both recognized and addressed by the Maltese Health Authorities.

Addressing the many issues at hand, even in the simplest cases of immigrant obstetric care, is a crucial and pressing need to ensure optimal management for the (mostly sub-Saharan) immigrant. Secondly, one must remember that even the best of intentions may carry serious malpractice liability. This obviously applies to all patient care, irrespective of ethnicity and socio-economic circumstances of the patient. Obstetric management of the sub-Saharan patient needs must conform to the European standard, the country is duty bound to give to one and all. Furthermore, such medico-legal awareness, can make for greater prudence, patience and communication, which if ensured at clinical practice level, can only serve to raise the medical service, in practice, as well as academically.

The phenomenon of mass irregular migration is one challenge, which is not likely to disappear, and in fact, most likely to be established in increasing amounts in the future. Working on the assumption that the status quo ante is history, it is essential that the management of the (sub-Saharan) immigrant be seen, as one based on long term planning. There is no place for "crisis management" but, rather, the need is one, calling for a full and on-going optimization from under-graduate education to senior post-graduate specialisation. Furthermore, pari

passu with such obstetric care optimization, the opportunity should also be taken up at legal, jurisprudential and medico-legal level. The challenges, current and more importantly, future, should not be laid aside, till individual problems arise evoking management resolutions by crisis. As discussed later on, the medico-legal aspect of the obstetric care of the immigrant woman, takes on a broader significance to the simple, usual implication of patient (as plaintiff) versus doctor (as defendant). The latter form of redress for liability resulting from negligence in not maintaining standards, is, needless to say, operative in the case of any patient, be she Maltese, English, American or sub-Saharan. At the moment, this is likely not to have a high profile for many obvious reasons, although it is likely to make its presence felt as immigrant status merges into resident's. The initial vulnerable state of the undocumented immigrant may swiftly change once official status is granted. Furthermore, vulnerability of patient, should never, ever, be used as basis of sub-standard medicine. Although, there exists no evidence, of this happening in Malta, the possibility may exist in any country facing similar situations.

Communication issues

Lack of communication renders life unpleasant at best, and dangerous at worst.

Borrowing from the UK's *Eldridge and Others v Attorney General of British Columbia and Another (Attorney General of Canada and Others, intervening)* [8] it comes, hardly, as news but needs re-iterating nonetheless, that effective communication is an integral part of medical care.

There are various vulnerable groups which are at greater risk of a break in communication with their doctor. This may include groups from the resident local population e.g. the hard of hearing (the above quoted Court case is an example of this group's difficulty in clinical communication), but, is much more likely to involve the immigrant, especially the sub-Saharan, irregular immigrant. Borrowing from the Canadian experience that "Somali women experienced miscommunication as a result of language barriers." [9].

This, most likely, applies to most European countries. It certainly does apply to the Maltese scene, where language difficulty, is the prime barrier, not only limiting empathy, but more crucially, the transference of clinically significant information, including medical history, symptomatology and management. And here, the immediate solution of an interpreter comes to mind, which solution is a direct violation of the patient's privacy. It is no easy matter, for a sub-Saharan woman, to discuss intimate matters with a strange obstetrician, via an interpreter, who may be known to her socially. Especially so, if both the interpreter and the strange gynaecologist happen to be males. It is hardly surprising that truth does not, on occasions, surface, with potential serious repercussions on obstetric management issues. These are problems which, with the best of intentions, are extremely difficult to rectify in an official way.

One may expand on the word 'barriers', quoted above, for language isolation is but the tip of the grave ethnic barrier rooted in "cultural knowledge, beliefs, religious and traditional preferences" [10]. The same quoted Canadian experience further concludes that these crucial psycho-social and religious elements are "often overlooked in Canadian maternity settings [10]." If looked for, the odds are in favour of the same conclusion in general, in Malta, as indeed elsewhere, such as Holland where: "These groups face similar problems, that is, the initial lack of knowledge on the Dutch health care system, language problems and difficulties arising in the communication with health care providers who have a different cultural background than the patient [11]."

Such an ethnic barrier, at times in spite of correct interpretation (not to be universally assumed), has multiple facets from the moment of the patient entering the doctor's office to the point of departure. Simple obstetric history may be distorted on purpose, especially if unknown to the present partner or husband, for fear of interpreter leakage, especially if of the sub-ethnic group. The necessity of advising the need for birth by a caesarean section instead of a normal delivery, may become a nightmare. Especially if going against the patient's inherent based on socio-cultural or even religious aspects. Obtaining a genuinely informed consent for an intervention would have medico-legal experts quaking. Incidentally, it is wise to have the interpreter sign such a consent form along with the patient. And, although interpreter drawbacks are among the elements evaluated here, we have not even touched on the aspect of an absent interpreter, for whatever reason, in cases of dire emergency e.g. fetal distress necessitating urgent caesarean section.

Socio-cultural issues

These factors may exercise their own difficulties in a clinical situation, although they may also influence obstetric care, through the above discussed communication barriers.

In Malta, as a rule, ethnic and socio-cultural diversity does not influence the delivery of an optimal obstetric service. Occasionally one hears of complaints of language difficulties, hygiene issues, (some of which are more perceived than real).. but it is difficult to detect any prejudice in the management of the obstetric immigrant, whether of sub-Saharan or other origin. In fact, it is quite often the opposite - carers are more frustrated by the inability to express empathy because of language barriers.

One is not, likely to meet ethnic or colour prejudice, as quoted in one USA study where:

“Objective differences in the quality of physician-patient communication among African American and White patients that mirror previously documented differences in patients' perceptions of their quality of health care.” [12].

The seriousness of such impaired communication cannot be downplayed because of the “empiric evidence for a direct, causal effect of the doctor-patient relationship on medical patients' treatment perceptions and malpractice claim intentions in the event of an adverse medical outcome.” [13].

There is no evidence at all, paralleling the USA experience that:

“African Americans get only about three quarters the high technology interventions prescribed for whites. They are more likely to be discharged in an unstable condition and more likely to have longer hospital stays.....Outpatient care is no different” [14].

Some UK experiences are similar: In one UK study, only 78% of eligible women were given an opportunity to decide whether or not to participate in prenatal screening, and this was associated with ethnicity. Only 67% of Afro-Caribbean women were offered screening, compared to 97% of white women.” [15].

Unless, of course, one is speaking of a situation where the immigrant refuses such high technology interventions for personal, religious or cultural reasons. For example, a number of situations have arisen, where an emergency caesarean section is advised and strongly resisted by the patient, her husband/partner or both. This might arise because of the “disadvantage at establishing rapport and patient bonding ...in any

acute labour ward situation.” [16].

However, the general impression is that the root cause is socio-cultural and possibly religious. It may include the perception of high mortality following surgery as is present in countries of origin or crossed in transit. Or even, the misconception that ‘once a caesarean, always a caesarean’, which fear may not be unfounded, especially if official status has not yet been granted or has been already refused. Such perceptions need understanding, patience and empathy – all of which may not come across, as intended, via translation. Furthermore, such lack of mutual understanding and patient-doctor bonding, may foster difficulties in situations where fear is induced and patient co-operation is necessary, as in the case of a forceps assisted delivery. Again, any interpretation in labour is of an even more delicate nature than in an antenatal visit and serious issues may arise if the interpreter turning up happens to be a male.

Medical issues

Immigrant obstetric medical issues may be myriad, and may also have some roots in socio-cultural basis as is present at birth in women who have undergone genital mutilation. This may vary from the simplest intervention, allowing vaginal delivery to proceed, to the most extreme, such as the Pharaonic (WHOType III FGM, mostly practised in northeastern Africa, particularly Djibouti, Eritrea, Ethiopia, Somalia and Sudan [17]. Unrelieved or if a caesarean section is not performed in time, this may lead to obstetric fistulae or even maternal death through haemorrhage [18].

Purely medical issues, cover a long list of items, which are an integral part of the challenge to the changing profile of the local maternity services in Malta. These may include:

1. The problems of malnutrition such as anaemia and various vitamin deficiencies.
2. Tropical diseases ranging from simple intestinal parasites to tuberculosis, HIV/AIDS and
3. Uncommonly, diseases like leprosy.
4. Non communicable diseases such genetic diseases, malignancies, renal failure, heart failure, mental illness and problems resulting from close consanguinity [19].
5. The effect of childhood starvation for example on the growth of the maternal pelvis or resulting in rickets. These may have a direct effect on the mode of delivery.
6. Different socio-cultural-religious practices e.g. the preference of female obstetricians.
7. Inherent resistance to certain procedures e.g. caesarean sections even in extreme danger to the unborn or the mother herself.

Furthermore, such potential medical problems may be compounded by lack of antenatal care, irregular antenatal care, a reticence of patient and doctor for antenatal genital examination or late presentations of new arrivals in labour. Missed or irregular antenatal care may be due to many reasons, including fear, shyness, misunderstanding or misinterpretation, lack of money for a bus, a jealous husband.... Whatever the cause, the sub-Saharan migrant is a prime example of the fact that

“There are ethnic differences in the frequency of adequate use of antenatal care, which cannot be attributed to differences in maternal age, gravidity and parity.” [19].

Furthermore, such patients are also likely to be late even in booking the initial visit for antenatal care [20]. The standard of care of the Maltese obstetric health system matters little, if it is not made use of as scheduled by the system. At the end of the day, the best care in the world, offers nothing to the patient who does not make satisfactory use of it. These factors are some contributing to Bryant et al.'s conclusion that As in other fields of medicine, obstetrical outcomes differ by maternal race/ethnicity. These disparities ultimately contribute to disparate rates of infant and maternal mortality, and thereby reflect the overall health status of the communities in which women and their families live [21].

For this group of women in Malta, an efficient obstetric system still equates to a poorly delivered service and may contribute to the fact that women with a non-western background contributed to 21.7% of the perinatal mortality [22]. In western countries, Malta included, it is imperative to bear in mind that: Compared to white women, blacks suffer more aggregate morbidities..... and... stand a high risk of all 3 intrapartum care-sensitive conditions. Furthermore, all women of color experience disproportionate rates of puerperal infections. Collective action is needed to reduce these disparities and improve maternal health [23].

Malta must not re-invent the wheel but borrow from countries which have already delineated such problems with the sub-Saharan pregnant women similar worrying findings come from Sweden where Somali women were found to be at an increased risk of intrauterine foetal death, small for date and low birth weight infants as well as serious maternal morbidity [24]. Austria noticing the same problems seeks to minimise such risks.

And again: "We recommend that action should be initiated in Austria toward harmonizing obstetric procedures among the migrant and the non-migrant groups and toward minimizing risk factors [25]. If anything, countries which experience sudden influxes of such patients, be they absolute or relative, as in a small population like Malta's, should be at an even greater alert, than countries which have such experiences with slowly increasing migrant populations. The system must reach out to the immigrant pregnant patient, and such efforts are in action in Malta.

Medico-Legal Encounters

The patient group under consideration may consider as both socially vulnerable as compared to regular migrants or local inhabitants [26]. This should compensatory increased medical awareness and assistance in pressing physical and psychological adjustment. Such adjustments are inevitable, if optimal care to them and their unborn, is the ultimate aim in their care. All censures by related NGO's with regard to sub-standard care of the pregnant immigrant, are always nationally face losing, apart from possibly being the first step in medico-legal litigation. One such censure directed at Malta, by Médecins sans frontières (MSF), involved the withdrawal of MSF from Malta on 13 March 2009 because the Maltese irregular migration detention centers lacked adequate facilities including health related facilities to these migrants held in detention [27].

Medico-legal entanglement involving the (sub-Saharan) irregular migrant, at this stage, in Malta, is unlikely to take the usual form expected, namely of patient suing for medical liability. This is, of course, inherent in all service, given by health providers including obstetricians, irrespective of the patient's ethnicity, religion, and cultural background. There is no section of the law, criminal or civil, which denies such a right, be the patient local, foreign, regular or irregular immigrant. At

the initial stages of settling in Malta, the immigrant, is unlikely, to seek legal redress for liability in real or perceived damage suffered from alleged sub-standard practice. The undocumented or irregular migrant awaiting acceptance or having been rejected, since they have breached immigration laws, may only have access to international human rights law [28] as is also the practice in countries like UK and France. It is hardly worth the exercise of going through all likely potential scenarios of immigrant obstetric management which is particularly vulnerable medico-legally. On the whole, as such and as yet, this is not likely to happen. This is, of course, pure theoretical reasoning, and there is, at least, one case example to the contrary. In Aslyia Aden Ahmed v Malta [29] the ECHR under violation of articles 3, 5-1, and 5-4 fined Malta 30,000 euros (£26,000; \$40,000), plus 3,000 euros in costs for action which led to her miscarriage. Admittedly this was not a case of malpractice but one should note that here the voice of the unborn is being successfully sounded in the European Court by an irregular immigrant using (rightly) her pregnancy to add weight to her situation. Even if malpractice, as such, was not the issue, it is still disconcerting to an obstetrician to hear the ECHR quoting "a complete lack of access to open air and exercise for periods of up to three months, an inadequate diet, and the particular vulnerability" in a woman carrying an unborn child.

As attitudes become more hostile to immigration in many European states, objections to irregular migrants' access to publicly funded health care have become stronger [29]. This, as yet, is not an issue in Malta. No doubt, significant medico-legal litigation, of any form, may tip the balance and should be pre-empted, ideally through optimal medical and medico-legal sound management.

However, the present scenario does give rise to medico-legal anxiety, if one reflects on simple basic points. One simple example would be the missing of crucial information, such as such precious stillbirths, illegal termination of pregnancy, uterine damage etc, and its effect on the management of pregnancy and labour.

The finding of liability on missing or not allotting due importance to medical history in pregnancy is, well known. One may quote one example from USA,. Park Chessin, the parents successfully sued for liability the obstetrician after the birth of the second child suffering from the same condition as their first (polycystic disease of the kidneys) [30]. Basically, they argued that they should have been warned about the possibility of recurrence, before proceeding with the second pregnancy. In Howard V. Lecher [31] the parents – Ashkenazic Jews of eastern European extraction, sued their obstetrician on the grounds that he failed to screen, in spite of a reasonably high incidence in their particular family and ethnic origin, of Tay Sachs disease [32]. These cases from the USA Courts do not concern irregular immigrants in Malta, but serve as potential and salutary reminders, of how things may go.

More factually and with feet on the ground, there are other matters which may raise their heads legally, irrespective whether at national or international Court. The European Union is witnessing obstetric oriented problems ranging from one end of the spectrum such as an unassisted birth in the middle of a squalid camp housing 11,500 in Idomeni (on the 23 March 2016), [33] to Court ordered caesarean sections, as has happened in Malta. It only takes a couple of successful test cases, say, in European Court, to set the medico-legal ball rolling in that direction.

Court ordered caesarean sections

The aspect of legal challenge from Court ordered caesarean sections requires much serious reflection. In Malta, this is resorted to, in the form of referral to the Attorney General, usually, when in emergency situations of risk to mother or baby, or both, the patient and the father of the child refuse permission to proceed with the intervention. However solid the indications for the proposed intervention are, and however well meant the intentions of the obstetric team are, this is a serious loophole of potential legal challengeability.

Firstly, one should note that whereas a caesarean section rate of 5-15% is considered by the World Health Organization as the optimal range for targeted provision of life saving intervention, in sub-Saharan Africa this is estimated as much lower, being 1-2%. [34]. One of the chief reasons is access to safe caesarean section for the sub-Saharan [35]. It is also worth bearing in mind that 90% [36] of the WHO estimated 350,000 [37] maternal deaths occur in under-resourced countries, where, among other factors, safe caesarean section is difficult to access.

With regard to the individual pregnant sub-Saharan woman's psyche, it is clear that caesarean section is not a mode of delivery, she is commonly exposed to. There may also be religious, social and cultural reasons why such a patient may refuse the offer of a caesarean section, even if, the risks to her unborn baby, to herself or to both, have been explained, normally through interpretation. Other reasons may be include fear of anesthesia, pain, and even death, harm to the fetus or herself, [38]. Language barriers and socio-economic factors may be an important factor of communication failure of the gravity of the situation. In a report from the United States, 81% of women refusing cesarean delivery were black, Hispanic, or Asian; 44% were unmarried; 24% did not speak English as their first language [38]. One must also bear in mind, that the patient may, in accepting a caesarean section on this occasion, be jeopardising any future childbearing, because, she may believe that "once a section, always a section." This fear may not be an unrealistic one, especially for the woman, still expecting a decision regarding her status, or even worse, if she has had her application revoked. Indeed, for such a worry, there may be no honest reassurance, except to state that the incidence of a future caesarean section will be higher, but is not necessarily and definitively so, unless the primary indication for it is repeated. Again, semi - reassurance across an interpreter, may lack conviction.

Refusal of a caesarean section may not come without its repercussions. In 2009, Ohel et al. [39] reviewing and comparing large numbers of women who accepted and refused caesarean section at delivery, found lower Apgar scores in the new-borns, and higher rates both of perinatal mortality as well as intrapartum death. Thus refusal may lead to greater fetal and maternal complications or both, even leading to death, greater fetal disability and future emotional scarring through guilt [40]. No one can deny that these potential complications are serious and interventional refusals should be meticulously recorded, with date, time, name of witnesses and name and details of the interpreter. Incidentally, even if consent is obtained, it is always wise to have the interpreter add his/her signature to the consent form.

Nothing is new under the sun, and naturally the concept of Court ordered intervention, including caesarean section, uncommon, but well documented, say in the United Kingdom and the USA. In the USA, some cases have reached the Supreme Court whereas in the UK, resolution was reached at or below the Court of Appeal [41]. These cases are not reported as including irregular migrants, whose right at law may be precluded by national law by the nature of their existence, but not at an international one. In the case of the migrant, whose presence has

been formally accepted, the situation is, naturally different, even with regard to the national law.

In surveys carried out by Kalder et al. [41] obstetricians' opinion on the matter, between 1987 and 2003 seems to have shifted radically in favour of the patient's wishes [42,43]. Of the series of patients looked at in these surveys, it is interesting to note that the ethnicity of the pregnant women studied were as follows: 81% were black, Asian or Hispanic, and 24% did not speak English as their primary language.

It was Justice Cardozo who as far back as 1914, enunciated:

Justice Cardozo stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault ..." [44].

This enunciation has not, by any means, had uniform acceptance since it was uttered more than a century ago. However, currently, the stress is on importance of consent as the core of autonomy, and hence medical treatment, in an adult of sound mind, whether the patient is pregnant or not [45]. There is little doubt that, generally speaking, both professionally and legally, maternal autonomy now demands respect [46] and patient choice or preference.

Both in the United States and in England, the common law that determines whether a competent pregnant woman should have control over her own body when she is carrying a viable fetus. Many countries do not recognise the legal right of the child in utero and hence maternal autonomy is considered supreme. This also applies to European Law. However, even in the United States, there are 36 states recognising the unborn fetus as a legal victim under the Unborn Victims of Violence Act of 2004 [47]. In some European countries such as Malta, the child has full legal protection - termination of pregnancy is in fact a criminal act. In some other countries such as Norway, the unborn has a constitutional status virtually similar to the born child.

By and large, both constitutionally and by obstetric practice, a forced caesarean section offers a viable liability target in a Court of law. In a Maltese Court. Because of the constitutional rights of the unborn, such a challenge to liability is more likely to be denied, although no one can speak for any particular Court, at any particular time. However, at European Court level, the situation is more than likely to go in favour of liability in the absence of maternal consent. Hopefully, time will not tell and no case will be put to the test. However, Malta must reflect constructively on this issue, which can arise, and does arise. One possible way out is for the establishment of an ethical committee which can advise and even take action. The latter may include the liaison of such a Committee with leaders of the sub-Saharan community, who have been in Malta for a substantial period of time and who understands the gravity of the situation, is available when called and explains fully the pros and cons of the situation to the parents. This goes well beyond simple translation of the interpreter on call.

There are, however, medico-legal encounters of a different nature, which are rather specific to this group of patients. This involves the physician's opinion on the risks involved in returning an applicant to their country of origin, taking into account their current condition, the treatments available in that country, and the risks involved in travel. These would involve failed asylum applications and may be doubly saddening when involving a pregnant woman.

Other related problems

This article, can but touch the tip of medico-legal oriented problems

of the irregular immigrant. The obstetrician may find himself dealing with many other aspects touching the law, when managing the pregnant. These may range from physical reports asked for by patients to submit, along with their requests for asylum. Here, the doctor must be true to facts and also state his opinion regarding travelling and other factors which may challenge the well-being of the pregnancy. Other aspects, include violence on the pregnant woman, at times, with respects to forego formal reporting of the culpable husband or partner, to avoid brushes with the law. In one Canadian study quoted by Stewart et al. [47] out of 774 pregnant immigrant women, 7.6% reported violence associated with pregnancy. Moreover, these same women were at an increased risk of violence if they lived without a partner, migrated less than 2 years previously, and had less than high school education. Furthermore they were also less likely to have up-to-date vaccinations, take folic acid before pregnancy, more likely to commence prenatal care after 3 months gestation and to not use contraceptives after birth.

Conclusion

Much physical and psychological abuse of the pregnant sub-Saharan goes unreported especially if occurring within the confines of a refugee center.

The final word in this challenging part of the sub-Saharan or other irregular immigrants, goes to an appeal for humanity. And, what is the practice of medicine without humanity?

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